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KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	550 HIGH ST. BOWLING GREEN, KY 42101

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F 000	INITIAL COMMENTS An abbreviated/partial extended survey (KY #18241, KY #18314 and KY #18344) was conducted on 05/02/12 through 05/11/12. KY #18241 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 05/09/12 and determined to exist on 02/17/12 at 42 CFR 483.10 Resident Rights at F157, 42 CFR 483.25 Quality of Care at F309, and 42 CFR 483.75 Administration at F514, at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care at F309. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 05/02/12, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be corrected on 04/28/12. On 02/17/12, while providing care to Resident #1, Physical Therapy Assistant (PTA) noticed a change of condition in the resident. She notified Registered Nurse (RN) #1 regarding the changes. On 02/17/12, RN #1 and RN #2 went to Resident #1's room and conducted an assessment of the resident. They reported they were unable to find a change of condition in Resident #1. There was no documentation that an assessment was conducted or the physician was notified. On 02/17/12 and 02/20/12, Resident #1's daughter reported to RN #5, the 3 PM to 11 PM shift nurse, that she had observed a change of condition in Resident #1. There was no documentation that an assessment was conducted or the physician was notified. On 02/21/12, the daughter reported to the Director of Nursing Services (DNS) that she had noticed a change of condition in	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 Resident #1 on 02/17/12. Resident #1 was sent to the Emergency Room (ER) for an evaluation on 02/21/12. After becoming aware of the incident, the facility initiated an investigation on 04/06/12. The facility developed and implemented interventions to correct the deficiency. Immediate Jeopardy was determined to exist on 02/17/12 through 04/28/12. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 05/02/12, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be corrected on 04/28/12. KY #18314 was substantiated with no deficiencies cited. KY # 18344 was unsubstantiated with no deficiencies cited.	F 000		
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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F 157	Continued From page 2 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's Investigative Report, and review of the facility's policy/procedure, it was determined the facility failed to consult/notify the resident's physician when there was a change of condition for one resident (#1), in the selected sample of three (3) residents. Resident #1 was admitted to the facility with a diagnosis to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis. On 02/17/12, Registered Nurse (RN) #1 was notified by the Physical Therapist Assistant (PTA) and State Registered Nurse Aide (SRNA) #1 about a noticeable change in condition for Resident #1. The resident was unable to turn his/her head and his/her left side neglect was worse. On 02/17/12, RN #1 and RN #2 assessed Resident #1's condition; however, no changes in condition were noted by the RNs.	F 157	Past noncompliance: no plan of correction required.	

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On 02/17/12 and again on 02/20/12, the resident's daughter noticed a marked difference in the resident. She revealed the resident was drawing up to the left side and not communicating as well as he/she had been. She revealed she told RN #5 about the resident's condition at that time; however, RN #5 stated she had not noticed any changes in the resident.

On 02/18/12, SRNA #3 revealed that there seemed to be a "360 degree change" in the resident. An assessment was completed by RN #3 and an LPN, on 02/18/12, with no noted changes. On 02/19/12, SRNA #3 again notified RN #3 about the resident's change in condition; however, there was no evidence RN #3 notified the physician nor sent the resident out to the hospital for further evaluation.

On 02/21/12, the resident's daughter spoke to the Director of Nursing Services (DNS) about the resident's condition. The resident was sent to the hospital and admitted on 02/21/12. The resident presented with an acute onset of left-side facial droop and deviation of his/her eyes to the left side. The physician revealed Resident #1 clearly showed evidence of a stroke on 02/21/12. The facility failed to provide documented evidence of an assessment for signs and symptoms of Resident #1's change in condition.

This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 02/17/12 through 04/28/12. The facility implemented corrective action which was completed prior to the State Agency's investigation, thus it was determined Past

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Jeopardy.

Findings include:

A review of the facility's policy/procedure, "Condition Change of a Resident," dated 10/31/06, revealed the physician should be informed at the time the event occurs either directly or by pager. An interview with the Physical Therapist, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, "It is PT policy, we notify nursing if we see a problem with a resident."

A record review revealed the facility admitted Resident #1 on 02/06/12 with diagnoses to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis on 12/20/11, History of Gastrointestinal Bleed and Chronic Renal Failure.

A review of the admission Minimum Data Set (MDS) assessment, dated 02/13/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of nine (9). The resident was totally dependent on one staff for dressing, personal hygiene and bathing. He/she required extensive assistance of two staff for bed mobility, transfer and toilet use and limited assistance with eating.

A review of a Weekly - Occupational Therapy (OT) Progress Note (PN), dated 02/13/12, revealed "[resident] demonstrates fair progression towards established goals including sitting tolerance 30-45 seconds. Left visual awareness with maximum verbal cues."

Review of a Physical Therapy (PT) Progress Note

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(PN), dated 02/14/12, revealed "improvement noted in tolerance and mobility." A review of a PT Rehab Addendum Note, dated 02/17/12, revealed "[resident] noted to have more significant left-side neglect today and unable to respond to verbal and tactile cues made from [his/her] left side. Whereas, yesterday, [he/she] was able to follow verbal cues. Nursing notified of recent changes." The document was signed by the Physical Therapist Assistant (PTA). An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, respectively, revealed while she was providing physical therapy to Resident #1 on 02/17/12, she noticed the resident with more left-sided neglect, and was unable to respond to verbal tactile cues or to follow her past midline, which was different from the previous day. She stated she returned the resident to the unit and reported the change of condition to RN #1. She stated she asked the nurse to assess the resident. She further stated approximately one hour later she followed up with RN #1. RN #1 told her that she did not see a change of condition in Resident #1. The PTA stated she also notified her PT supervisor of the change of condition in Resident #1. An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed when Resident #1 was admitted to the facility he/she was able to move the right arm, turn his/her head and wiggle his/her toes. She stated that she and the PTA, on 02/16/12 or 02/17/12, noticed the resident was unable to turn his/her head. "It just stayed to the side. He/she stopped wiggling his/her toes and fingers and that was a difference." RN #1 was notified regarding the resident's change of condition. She stated RN #1 informed them that Resident #1 had a stroke, and this was why he/she was like that. She stated

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she told RN #1 the resident was not like that a few days ago.

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed, on 02/17/12, that PTA had contacted RN #1 related to Resident #1's change in condition. RN #1 said she did not see any change in Resident #1 and asked me to go with her to assess the resident on 02/17/12. She stated, that on 02/17/12, she was unaware that the PTA had reported a change in condition in the resident. She stated "I just knew someone had reported a change in the resident. I thought everything was fine, because I did not see a change in the resident."

An interview with the Resident #1's daughter, on 05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, respectively, revealed she reported to RN #5, on the 3 PM to 11 PM shift, on 02/17/12 and 02/20/12, that she had noticed a marked difference in the resident. She stated she advised RN #5 the resident was not communicating as well and drawing up to the left side. She stated the nurse said she had not noticed any change at all in the resident.

There was no evidence the physician was notified regarding the resident's condition and no documented evidence that the nursing staff determined there was a significant change in the resident's condition.

An interview with SRNA #3, on 05/06/12 at 9:05 and 9:22 AM, revealed she worked on 02/18/12 and 02/19/12 on the 11-7 shift and had provided care for Resident #1. She stated the resident, prior to 02/18/12, had wanted to get up and help

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with toileting. She stated, on 02/18/12 and 02/19/12, the resident was less eager to help and did not seem happy. She stated "it was like a 360 degree change." She stated she notified RN #3 that "the resident seemed different and was not [himself/herself]." She stated RN #3 and an LPN assessed the resident on 02/18/12. She further stated when she returned to work, on 02/19/12, she felt perhaps the resident had not progressed and his/her condition was a little worse. She said she notified RN #3 again and the two of them went in the resident's room. She stated RN #3 asked her to stay in the room and watch the resident. She stated RN #3 stated "God, I hope she does not die." She stated she asked the nurse "was she going to send the resident out." She stated RN #3 said, "No, I cannot send [him/her] out." SRNA #3 stated "I do not know what she meant by that."

An interview with RN #3, on 05/03/12 at 4:00 PM, revealed she did not recall a change in Resident #1's condition. She stated she did not receive a report from anyone about a change in the resident's condition.

There was no evidence the physician was notified regarding the resident's condition and no documented evidence that the nursing staff determined there was a significant change in the resident's condition.

A review of a Weekly - Occupational Therapy (OT) PN, dated 02/20/12, revealed [resident] demonstrates "sitting tolerance 45 seconds to one (1) minute. [Resident] presents with severe left neglect during therapy, decreased positioning, decreased balance and decreased strength, left

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hemiplegia and left neglect."

A review of the OT Rehab Addendum Note, dated 02/20/12, revealed "nursing notified of [resident's] worsening of status including, severe left neglect/decreased reaction, impaired posture control and suspicion of additional CVA with nursing currently addressing/verbalizing understanding."

An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, revealed she and the Occupational Therapist (OT), on 02/20/12, co-treated Resident #1 because he/she was a difficult resident. She stated she asked the OT to report a change in the resident's condition to the nurse since she had reported the change to the nurse on Friday, 02/17/12. She revealed, "If more than one person notices a change, I like to make sure the nurse knows it is more than one discipline."

An interview with the OT, on 05/03/12 at 11:55 AM, revealed, prior to 02/17/12, she was able to cue Resident #1 to attend to his/her left visual field. She stated, that on 02/20/12, she noticed the resident's left-side neglect was much more severe. "I had to physically try to move the resident's head to the left." On 02/20/12, she notified RN #1 immediately of the change of condition and documented that information. She stated RN #1 advised her that she soul contact the resident's daughter. She verbalized understanding of what I was reporting to her. Later, on 02/20/12, I followed-up with RN #1. Again, the RN advised me she would contact the daughter. She further stated "I expected the nurse would contact the physician and report the

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change in condition."

A review of the nurse's notes, dated 02/17/12 through 02/20/12, revealed no evidence that the physician was notified regarding a change in condition. The first notation related to a change in condition for Resident #1 was on 02/21/12 at 9:00 AM. A Change of Condition Form revealed "Resident's family states that the resident is exhibiting signs and symptoms similar to those related to a previous CVA, such as pocketing food, inability to focus/concentrate and slight left-sided neglect. Requesting the resident be sent to the hospital for an evaluation. The physician was made aware with a new order received to send to the ER for an evaluation to rule out CVA."

A review of the Magnetic Resonance Imaging (MRI) report, completed on 02/21/12, revealed "Impression: Acute ischemic changes were seen around the peripheral area of chronic ischemic changes in the distribution of the right middle cerebral artery in the right temporal parietal lobe."

An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, revealed, on the morning of 02/21/12, as she began physical therapy with Resident #1, his/her daughter came to the therapy room and asked if she had noticed a change in Resident #1. She stated she told the daughter she had noticed a difference on 02/17/12. She stated the daughter asked if there was someone she could speak to. She stated she escorted the daughter to the DNS. PTA stated "Resident #1 was sent out of the facility." Further review of a PT PN, dated 02/21/12, revealed "Resident #1 experienced a decline in

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condition at the end of last week, nursing notified of change and decline in status, left-side neglect, decreased strength, decreased mobility and decreased sitting balance."

An interview with the PT, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, she was aware there was a change of condition in Resident #1, because the PTA notified her that there had been a change in condition for Resident #1. She stated that she and PTA discussed the changes related to his/her ability to follow cues and balance. She stated she advised the PTA to notify the nurse about the change of condition. She further stated "I know that the change, we noted, was not transient." She stated she was aware that OT also noted a change of condition in Resident #1 and documented the same in her addendum note.

An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed, that on the morning of 02/21/12, while as she was assisting the resident with eating breakfast, the resident's daughter came in. She stated the daughter commented to her that the resident was "pocketing food worse." She stated the daughter asked her about a change in the resident, and I told her noticed it and had reported it to my nurse. SRNA #1 then asked RN #1 to speak to the daughter. She stated the daughter became upset with RN #1 regarding not being notified about Resident #1's change in condition. She stated RN #1 told the daughter she spoke to someone about the resident's change in condition; however, the resident's daughter revealed, "No one talked to me."

An interview with the Resident #1's daughter, on

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05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, revealed, on 02/21/2, she spoke with the PTA and asked about a change of condition in the resident. She told me yes, and there was documentation about a change of condition in Resident #1. The daughter stated she asked the PTA why she was not notified. She stated the PTA told her she did not know the answer, but she had done what she was suppose to do by notifying the nurse. She stated the PTA took her to the DNS's office. She stated she spoke to the DNS about a noticeable change in the resident on 02/17/12, which she reported to RN #5. She stated she informed the DNS that the nurse had made her feel like she was overly concerned or exaggerating. She stated the DNS revealed the nurse had not made a report of the change in condition. The daughter stated "the nurse should have listened to my concerns, listened to the PTA and should have sent [the resident] to the hospital for evaluation."

A review of the OT Discharge Summary, dated 02/22/12, revealed "[resident] demonstrates noted regression secondary to increased left neglect with patient demonstrating right lateral cervical rotation to 80 degrees, unable to cross midline to left. [Resident] also with significant left lateral lean with suspected worsening of conation times one day observation of therapist."

A review of the PT Discharge Summary, dated 02/22/12, revealed "treatment initially successful; however, overall to date no progress related to the recent decline. Reason for Discharge: Change in medical status requiring hospitalization."

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A review of a Teachable Moment - Education Form, dated 03/21/12, revealed the facility conducted a teachable moment with RN #1 by the DNS related to improved communication and customer satisfaction. The discussion with an employee and the reason for a teachable moment was related to, "if therapy staff communicates a concern with a resident, communicate with the family after assessing the resident. If your assessment does not indicate a problem but the family is still concerned, communicate their concern to the physician. Ask the family what they would like done, whether to treat in house or send for an evaluation to the Emergency Room (ER)." The document was signed by the DNS and RN #1.

A review of a Teachable Moment - Education Form, undated, revealed the facility conducted a teachable moment with RN #2 by the DNS related to accurate documentation of a resident's change in condition. The discussion with an employee and the reason for a teachable moment was related to, "On 02/17/12 you accompanied RN #1 to do an assessment on Resident #1 with a reported change in condition. As the Unit Manager, it is your responsibility to make sure the assessment was documented." The document was signed by the DNS and RN #2.

A review of the facility's Final Investigation Summary, dated 04/13/12, revealed, on 02/17/12, Physical Therapist Assistant (PTA) notified RN #1 about a change of condition in Resident #1. She informed RN #1 the resident's left side neglect was worse. RN #1 followed-up with the PTA and advised the PTA that the resident was lying on

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his/her left side in the bed and the resident was able to track her all the way to the window. The PTA stated the resident's daughter approached her in the therapy department, on 02/21/12, and asked about any noticeable changes in the resident. PTA stated that she told the resident's daughter that she reported a change to nursing and took the resident's daughter to the DNS's office. RN #2 stated, that on 02/17/12, RN #1 came to her and advised her that therapy had voiced a concern about a change in condition regarding Resident #1. RN #2 and RN #1 assessed Resident #1, and did not notice any changes in his/her condition. Upon the resident's admission on 02/06/12, RN #2 completed Resident #1's skin assessment. The area on the resident's left buttock was a Stage III and measured 2.8 centimeters (cm) by 2.0 cm. The area had necrotic tissue over 50% but less than 75% of the wound. Treatment was Santyl with foam and a dry dressing. SRNA #1 stated she noticed something different about Resident #1 and told RN #1 on 02/17/12.

An interview with RN #1 was attempted, on 05/02/12 and 05/03/12 at 3:10 PM and 9:20 AM, respectively; however, the surveyor was unable to leave a message. Voice mail stated, "the party you are attempting to reach is not accepting calls at this time."

An interview with the DNS, on 05/02/12 at 2:55 PM, revealed she first became aware of a concern with Resident #1 on the morning of 02/21/12. She stated the PTA brought Resident #1's daughter to her office because she was "upset about the resident's condition." She stated the daughter told her she was noticing some of

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the same symptoms the resident had exhibited with his/her prior stroke, "pocketing food and looking to the left." She stated, she and the daughter went to the resident's room to assess the resident. The resident had just finished breakfast, and he/she still had oatmeal in his/her mouth. She stated the daughter wanted the resident sent to the Emergency Room (ER). She further stated after the resident was sent out to the hospital, she went to RN #1 and RN #2 and asked them, what happened on 02/17/12. They stated the PTA had advised them of a change of condition in Resident #1. RN #1 and RN #2 told me they did an assessment, and they did not observe a change of condition with the resident. She further stated they did not document the assessment and had no reason for not documenting the assessment. She stated she addressed with RN #1 and RN #2 when a change of condition was reported, they were to complete a Situation Background Assessment Request (SBAR) form, and then they were to notify the physician. She further stated she did re-education with RN #1 and RN #2 related to completing the SBAR, physician notification and being an advocate for the resident and family. She stated, "It is not at the nurse's discretion not to report. They are required to report even if it is just the family reporting a change to them."

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed the resident's grip, swallowing ability and speech were assessed. She added that she did not notice a change in the resident's condition. She asked RN #1 to "make a good nurse's note, but neither of us documented the assessment." She further stated the DNS did a Teachable Moment with me to be sure to follow-up with the

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nurse to make sure documentation was completed.

Resident #1's physician revealed, in an interview, on 05/03/12 at 10:00 AM, revealed that, on 02/21/12, he admitted Resident #1 to the hospital. He stated the resident presented with acute onset of left-side facial droop and deviation of his/her eyes to the left side. He stated the resident "clearly showed evidence of a stroke on 02/21/12. He revealed if a person shows signs of a stroke, we want them sent to the ER right away. He stated the MRI, on 02/21/12, revealed the resident had a stroke.

**The facility implemented the following actions to correct the deficiency:

*The resident's physician/medical director was notified of the resident's change in condition on 02/21/12 and he/she was sent to the ER.

* The facility had an Ad Hoc PI meeting held on 04/06/12 with IDT to review communication between departments and shifts, customer service, changes in resident condition and notification of changes in condition.

*An in-service was conducted for all staff, on 04/06/12, to educate them on the Stop and Watch form, the 24 hour report book, being an advocate for the customers, the SBAR form with a change of condition, and guidelines for physician notification on change of condition.

*An audit tool was implemented to identify residents with a change in condition. The audit tool is ongoing on residents with a change in

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condition.

**The surveyor validated the corrective action taken by the facility as follows:

*A review of the Teachable Moment Education Form for RN #1, dated 03/21/12, and RN #2, undated, revealed the two (2) nurses received education by the DNS.

*A review of the Ad Hoc PI Meeting Attendance and Agenda form, dated 04/06/12, revealed the agenda topics discussed included: Communication between departments and shifts, customer service, SBAR with reported change in condition and notification on changes in condition. The staff present were DNS, Social Services, Nutrition Services, Activities Director, Environmental Services and Licensed nurse. The document was signed by all staff present.

*A review of inservices, dated 04/06/12, revealed all staff were educated on Resident Change in Condition and Stop and Watch Form "Whenever a change of condition is identified in a resident, a Stop and Watch Form is to be filled ou and given to the Charge Nurse before the end of the shift." Documentation of Resident Change in Condition "Whenever a change of condition is identified in a resident, the SBAR Form must be filled out before the physician is notified. The completed form is to be placed in the progress notes. All changes in condition must be written on the 24 hour report book to pass on to the oncoming shift for follow up." Guidelines for Physician Notification of Change in Condition "When you have a resident with a change in condition, refer to the Guidelines for Physician Notification of

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Change of Condition Tool to determine the timeline of notification. The Guidelines are located on all Medication Administration Record (MAR) books and can be pulled from the computer TL6102-03." Customer Service "When a family or resident voice a concern, particularly on a change in condition, proper notification must be made. Even if we don't see the problem they have brought to us, it is a huge problem to the person voicing the concern. The staff is to act as advocates for our resident and families." Therapy, Dietary, Activities and Housekeeping were inserviced related to completing a Stop and Watch form. A list of employees was compared against the inservice sign in sheets. All employees were inserviced on 04/06/12.

*A review of a Teachable Moment - Education Form, dated 04/18/12, revealed LPN #2 received a teachable moment from LPN #1 related to evaluation of a resident's for change in condition via SBAR evaluation form, complete thorough evaluation. The discussion with the employee and reason for the teachable moment was related to, "failed to complete SBAR assessment tool with a condition change of Resident 150 B left eye read and draining. The document was signed by LPN #1 and LPN #2.

*A review of a Teachable Moment - Education Form, dated 04/23/12, revealed RN #7 received a teachable moment from the Assistant Director of Nursing Services (ADNS) related to completing an SBAR evaluation form. The discussion with the employee and reason for the teachable moment was related to, "any time you are given a Stop and Watch form, an SBAR must be filled out. The document was signed by RN #1 and

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F 157	Continued From page 18 ADNS. *An interview with the DNS, on 05/08/12 at 9:35 AM, revealed the facility had a PI meeting on 04/27/12 to follow up on a corrective action plan. The only issue identified was two (2) nurses, RN #7 and LPN #1, had missed completing the SBAR form. She stated a teachable moment with the two (2) nurses was completed. She stated the facility had implemented a change of condition audit tool and had identified all residents that needed to be sent out of the facility. She stated the facility continued to utilize the change of condition audit tool. *An interview with RN #7, LPN #2, LPN #3, SRNA #5, SRNA #6, SRNA #7, Housekeeping staff, and COTA #2, on 05/08/12 between 11:14 AM and 12:40 PM, revealed they were inserviced on the stop and watch form, who to report a change in condition to, completing the SBAR, assess the resident, notify the physician, supervisor, ADNS and document the assessment. No concerns were identified. *An interview with the Medical Director, on 05/03/12 at 12:30 PM, revealed the facility notified him of the change in condition for Resident #1 on 02/21/12 and the staff was directed to send the resident to the ER.	F 157		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 19 and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure, and review of the facility's Investigative Report, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment for one resident (#1), in the selected sample of three (3) residents. The facility failed to follow their "Condition Change of a Resident" policy and procedure. Resident #1 was admitted to the facility with a diagnosis to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis. On 02/17/12, Physical Therapist Assistant (PTA), State Registered Nurse Aide (SRNA) #1 and the Resident's daughter notified facility nurses about a noticeable change in condition for Resident #1. The resident's left side neglect was worse and he/she was unable to turn his/her head. On 02/18/12 and 02/19/12, SRNA #3 notified a facility nurse that there seemed to be a "360 degree change" in the resident. On 02/20/12, the Occupational Therapist (OT) notified nursing "of [resident's] worsening of status including, severe left neglect/decreased reaction, impaired posture control and suspicion of additional CVA with nursing currently addressing/verbalizing understanding." There was no documented evidence that facility nurses assessed Resident #1 for a change in condition, communicated the	F 309	Past noncompliance: no plan of correction required.	

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concerns reported to oncoming shift nurses or notified the physician of the multiple reports of a change in Resident #1. On 02/21/12, the resident's daughter spoke with the Director of Nursing Services (DNS). The resident was was sent out and admitted to the hospital. He/she presented with an acute onset of left-side facial droop and deviation of his/her eyes to the left side. The physician revealed Resident #1 clearly showed evidence of a stroke on 02/21/12. The facility failed to provide documented evidence of an assessment for signs and symptoms of a change in condition for Resident #1.

This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 02/17/12 through 04/28/12. The facility implemented corrective action which was completed prior to the State Agency's investigation, thus it was determined Past Jeopardy.

Findings include:

A review of the facility's policy/procedure, "Condition Change of a Resident," dated 10/31/06, revealed it is the responsibility of the licensed nurse to "assess resident, take vital signs and include temperature, gather and organize the resident information (chart, medication list, vital signs, etc.) for physician notification, monitor and reassess resident's condition and response to interventions until stable." An interview with the Physical Therapist (PT), on 05/04/12 at 10:30 AM, revealed "It is PT policy, we notify nursing if we see a problem with a resident."

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A record review revealed the facility admitted Resident #1 on 02/06/12 with diagnoses to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis on 12/20/11, History of Gastrointestinal Bleed and Chronic Renal Failure. A review of the admission Minimum Data Set (MDS) assessment, dated 02/13/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of nine (9). The resident was totally dependent on one staff for dressing, personal hygiene and bathing. He/she required extensive assistance of two staff for bed mobility, transfer and toilet use and limited assistance with eating.

A review of a Weekly - Occupational Therapy (OT) Progress Note (PN), dated 02/13/12, revealed "[resident] demonstrates fair progression towards established goals including sitting tolerance 30-45 seconds. Left visual awareness with maximum verbal cues." A review of a Physical Therapy (PT) Progress Note (PN), dated 02/14/12, revealed "improvement noted in tolerance and mobility."

A review of a PT Rehab Addendum Note, dated 02/17/12, revealed "[resident] noted to have more significant left-side neglect today and unable to respond to verbal and tactile cues made from [his/her] left side. Whereas, yesterday, [he/she] was able to follow verbal cues. Nursing notified of recent changes." The document was signed by the Physical Therapist Assistant (PTA). An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, respectively, revealed while she was providing physical therapy to Resident #1 on 02/17/12, she noticed the resident

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with more left-sided neglect, and was unable to respond to verbal tactile cues or to follow her past midline, which was different from the previous day. She stated she returned the resident to the unit and reported the change of condition to RN #1. She stated she asked the nurse to assess the resident. She further stated approximately one hour later she followed up with RN #1. RN #1 told her that she did not see a change of condition in Resident #1. The PTA stated she also notified her PT supervisor of the change of condition in Resident #1. An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed when Resident #1 was admitted to the facility he/she was able to move the right arm, turn his/her head and wiggle his/her toes. She stated that she and the PTA, on 02/16/12 or 02/17/12, noticed the resident was unable to turn his/her head. "It just stayed to the side. He/she stopped wiggling his/her toes and fingers and that was a difference." We notified RN #1 regarding the change of condition. She stated RN #1 told them that Resident #1 had a stroke, and this was why he/she was like that. She stated she told RN #1 the resident was not like that a few days ago. An interview with the PT, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, she was aware there was a change of condition in Resident #1, because the PTA notified her that there had been a change in condition for Resident #1. She stated that she and PTA discussed the changes related to his/her ability to follow cues and balance. She stated she advised the PTA to notify the nurse about the change of condition.

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed that PTA, on 02/17/12, had contacted RN #1 related to Resident #1's change in

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condition. RN #1 said she did not see any change in Resident #1 and asked me to go with her to assess the resident on 02/17/12. She stated, that on 02/17/12, she was not aware that the PTA had reported a change of condition in the resident. She stated "I just knew someone had reported a change in the resident. I thought everything was fine, because I did not see a change in the resident."

An interview with the Resident #1's daughter, on 05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, respectively, revealed she reported to RN #5, on the 3 PM to 11 PM shift, on 02/17/12 and 02/20/12, that she had noticed a marked difference in the resident. She stated she advised RN #5 the resident was not communicating as well and drawing up to the left side. She stated the nurse said she had not noticed any change at all in the resident.

There was no evidence facility staff notified the physician regarding the resident's condition and no documented evidence that the nursing staff conducted an assessment to determine if there was a significant change in the resident's condition on 02/17/12.

An interview with SRNA #3, on 05/06/12 at 9:05 and 9:22 AM, revealed she worked on 02/18/12 and 02/19/12 on the 11-7 shift and had provided care for Resident #1. She stated the resident, prior to 02/18/12, had wanted to get up and help with toileting. She stated, on 02/18/12 and 02/19/12, the resident was less eager to help and did not seem happy. She stated "it was like a 360 degree change." She stated she notified RN #3 that "the resident seemed different and was not

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[himself/herself]." She stated RN #3 and an LPN assessed the resident on 02/18/12. She further stated when she returned to work, on 02/19/12, she felt perhaps the resident had not progressed and his/her condition was a little worse. She said she notified RN #3 again and the two of them went in the resident's room. She stated RN #3 asked her to stay in the room and watch the resident. She stated RN #3 stated "God, I hope she does not die." She stated she asked the nurse "was she going to send the resident out." She stated RN #3 said, "No, I cannot send [him/her] out." SRNA #3 stated "I do not know what she meant by that."

An interview with RN #3, on 05/03/12 at 4:00 PM, revealed she had no recollection of a change in condition in Resident #1. She stated she did not get a report from any staff or nurses about a change in the resident's condition.

There was no evidence facility staff notified the physician regarding the resident's condition and no documented evidence that the nursing staff conducted an assessment to determine if there was a significant change in the resident's condition on 02/18/12 or 02/19/12.

A review of a Weekly - Occupational Therapy (OT) PN, dated 02/20/12, revealed [resident] demonstrates "sitting tolerance 45 seconds to one (1) minute. [Resident] presents with severe left neglect during therapy, decreased positioning, decreased balance and decreased strength, left hemiplegia and left neglect."

A review of the OT Rehab Addendum Note, dated 02/20/12, revealed "nursing notified of [resident's]

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worsening of status including, severe left neglect/decreased reaction, impaired posture control and suspicion of additional CVA with nursing currently addressing/verbalizing understanding."

An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, revealed she and the Occupational Therapist (OT), on 02/20/12, were co-treating Resident #1 because he/she was a difficult resident. She stated she asked the OT to report a change of condition to the nurse since she had reported the change to the nurse on Friday, 02/17/12. She stated, "If more than one person notices a change, I like to make sure the nurse knows it is more than one discipline."

An interview with the OT, on 05/03/12 at 11:55 AM, revealed, prior to 02/17/12, she was able to cue Resident #1 to attend to his/her left visual field. She stated, that on 02/20/12, she noticed the resident's left-side neglect was much more severe. "I had to physically try to move the resident's head to the left." She said she notified RN #1 immediately of the change of condition on 02/20/12 and documented that nursing was notified. She stated RN #1 advised her that she would contact the daughter. She verbalized understanding of what I was reporting to her. Later, on 02/20/12, I followed up with RN #1. She again advised me she was going to contact the daughter. She further stated "I expected the nurse would contact the physician and report the change of condition."

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed they assessed the resident's grip,

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swallowing ability and speech. She stated she did not notice a change in the resident's condition. She stated she asked RN #1 to "make a good nurse's note, but neither of us documented the assessment." A review of the nurse's notes, dated 02/17/12 through 02/20/12, revealed no evidence of a nursing assessment for Resident #1 or that the physician was noted of a change in condition.

An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed, that on the morning of 02/21/12, while she was assisting the resident with eating breakfast, the resident's daughter came in. She stated the daughter commented the resident was "pocketing food worse." She stated the daughter asked if I had noticed a change in the resident, and I told her yes, and I had reported it to my nurse. SRNA #1 asked RN #1 to speak to the daughter. She stated the daughter became upset with RN #1 about not being notified about Resident #1's change in condition. She stated RN #1 told the daughter she had talked to someone. The daughter stated "No one talked to me." An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, revealed, on the morning of 02/21/12, as she began physical therapy with Resident #1, his/her daughter came to the therapy room and asked if she had noticed a change in Resident #1. She stated she told the daughter she had noticed a difference on 02/17/12. She stated the daughter asked if there was someone she could speak to. She stated she escorted the daughter to the DNS. PTA stated "Resident #1 was sent out of the facility." Further review of a PT PN, dated 02/21/12, revealed "Resident #1 experienced a decline in

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condition at the end of last week, nursing notified of change and decline in status, left-side neglect, decreased strength, decreased mobility and decreased sitting balance." An interview with the PT, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, she was aware there was a change of condition in Resident #1, and further stated "I know that the change, we noted, was not transient." She stated she was aware that OT also noted a change of condition in Resident #1 and documented the same in her addendum note.

An interview with the Resident #1's daughter, on 05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, revealed she spoke with the PTA on 02/21/12, and asked her if she had noticed a change in the resident. She told me yes, and she had documented there was a change of condition in Resident #1. The daughter stated she asked the PTA why no one had notified her. She stated the PTA told her she did not know why I was not notified, but she had done what she was suppose to do by notifying the nurse. She stated the PTA took her to the DNS's office. She further stated she advised the DNS that she had noticed a change in the resident on 02/17/12, and that she had reported the change to RN #5. She stated she informed the DNS that the nurse had made her feel like she was overly concerned or exaggerating. She stated the DNS said the nurse had not made a report of the change of condition. The daughter stated "the nurse should have listened to my concerns, listened to the PTA and should have sent [the resident] to the hospital for evaluation."

The first notation related to a change of condition

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for Resident #1 in the medical record was on 02/21/12 at 9:00 AM. A Change of Condition Form revealed "Resident's family states that the resident is exhibiting signs and symptoms similar to those related to a previous CVA, such as pocketing food, inability to focus/concentrate and slight left-sided neglect. Requesting the resident be sent to the hospital for an evaluation. The physician was made aware with a new order received to send to the ER for an evaluation to rule out CVA."

A review of the Magnetic Resonance Imaging (MRI) report, completed on 02/21/12, revealed "Impression: Acute ischemic changes were seen around the peripheral area of chronic ischemic changes in the distribution of the right middle cerebral artery in the right temporal parietal lobe."

A review of the OT Discharge Summary, dated 02/22/12, revealed "[resident] demonstrates noted regression secondary to increased left neglect with patient demonstrating right lateral cervical rotation to 80 degrees, unable to cross midline to left. [Resident] also with significant left lateral lean with suspected worsening of conation times one day observation of therapist."

A review of the PT Discharge Summary, dated 02/22/12, revealed "treatment initially successful; however, overall to date no progress related to the recent decline. Reason for Discharge: Change in medical status requiring hospitalization."

A review of a Teachable Moment - Education Form, dated 03/21/12, revealed the facility conducted a teachable moment with RN #1 by

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the DNS related to improved communication and customer satisfaction. The discussion with an employee and the reason for a teachable moment was related to, "if therapy staff communicates a concern with a resident, communicate with the family after assessing the resident. If your assessment does not indicate a problem but the family is still concerned, communicate their concern to the physician. Ask the family what they would like done, whether to treat in house or send for an evaluation to the Emergency Room (ER)." The document was signed by the DNS and RN #1.

A review of a Teachable Moment - Education Form, undated, revealed the facility conducted a teachable moment with RN #2 by the DNS related to accurate documentation of a resident's change in condition. The discussion with an employee and the reason for a teachable moment was related to, "On 02/17/12 you accompanied RN #1 to do an assessment on Resident #1 with a reported change in condition. As the Unit Manager, it is your responsibility to make sure the assessment was documented." The document was signed by the DNS and RN #2.

A review of the facility's Final Investigation Summary, dated 04/13/12, revealed, on 02/17/12, Physical Therapist Assistant (PTA) notified RN #1 that she noticed a change of condition in Resident #1. She advised RN #1 the resident's left side neglect was worse. RN #1 followed up with the PTA and advised the PTA that the resident was lying on his/her left side in the bed and the resident was able to track her all the way to the window. The PTA stated the resident's

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daughter approached her in the therapy department, on 02/21/12, and asked her if she had noticed any changes in the resident. PTA stated that she told the resident's daughter that she reported a change to nursing and took the resident's daughter to the DNS's office. RN #2 stated, that on 02/17/12, RN #1 came to her and advised her that therapy had voiced a concern about a change in condition regarding Resident #1. RN #2 accompanied RN #1 to assess Resident #1. They did not notice any changes in his/her condition. RN #2 completed Resident #1's skin assessment upon admission on 02/06/12. The area on the resident's left buttock was a Stage III and measured 2.8 centimeters (cm) by 2.0 cm. The area had necrotic tissue over 50% but less than 75% of the wound. Treatment was Santyl with foam and a dry dressing. SRNA #1 stated she noticed something different about Resident #1 and told RN #1 on 02/17/12. An interview with the DON, on 05/04/12 at 2:50 PM, revealed she did not realize there was a problem until Adult Protective Services (APS) came to the facility, on 04/06/12, and requested copies of the resident's chart concerning a pressure sore and the resident's stroke. She stated she was informed by APS about the concern, and she initiated an investigation at that time. Through their investigation process, the facility determined there were no neglect issues regarding Resident #1, and unsubstantiated the allegation.

An interview with RN #1 was attempted, on 05/02/12 and 05/03/12 at 3:10 PM and 9:20 AM, respectively, and was unable to leave a message. Voice mail stated, "the party you are attempting to reach is not accepting calls at this time."

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F 309	Continued From page 31 An interview with the DNS, on 05/02/12 at 2:55 PM, revealed she first became aware of a concern with Resident #1 on the morning of 02/21/12. She stated the PTA brought Resident #1's daughter to her office because she was "upset about the resident's condition." She stated the daughter told her she was noticing some of the same symptoms the resident had exhibited with his/her prior stroke, "pocketing food and looking to the left." She stated, she and the daughter went to the resident's room to assess the resident. The resident had just finished breakfast, and he/she still had oatmeal in his/her mouth. She stated the daughter wanted the resident sent to the Emergency Room (ER). She further stated after the resident was sent out to the hospital, she went to RN #1 and RN #2 and asked them, what happened on 02/17/12. They stated the PTA had advised them of a change of condition in Resident #1. RN #1 and RN #2 told me they did an assessment, and they did not observe a change of condition with the resident. She further stated they did not document the assessment and had no reason for not documenting the assessment. She stated she addressed with RN #1 and RN #2 when a change of condition was reported, they were to complete a Situation Background Assessment Request (SBAR) form, and then they were to notify the physician. She further stated she did re-education with RN #1 and RN #2 related to completing the SBAR, physician notification and being an advocate for the resident and family. She stated, "It is not at the nurse's discretion not to report. They are required to report even if it is just the family reporting a change to them."	F 309		

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An interview with Resident #1's physician, on 05/03/12 at 10:00 AM, revealed that he admitted Resident #1 to the hospital on 02/21/12. He stated he/she presented with acute onset of left-side facial droop and deviation of his/her eyes to the left side. He stated Resident #1 "clearly showed evidence of a stroke on 02/21/12. He stated if a person shows signs of a stroke, we want them sent to the ER right away. He stated the MRI on 02/21/12 revealed the resident had a stroke.

**The facility implemented the following actions to correct the deficiency:

*The resident's physician/medical director was notified of the resident's change in condition on 02/21/12 and he/she was sent to the ER.

* The facility had an Ad Hoc PI meeting held on 04/06/12 with IDT to review communication between departments and shifts, customer service, changes in resident condition and notification of changes in condition.

*An in-service was conducted for all staff, on 04/06/12, to educate them on the Stop and Watch form, the 24 hour report book, being an advocate for the customers, the SBAR form with a change of condition, and guidelines for physician notification on change of condition.

*An audit tool was implemented to identify residents with a change in condition. The audit tool is ongoing on residents with a change in condition.

**The surveyor validated the corrective action

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taken by the facility as follows:

*A review of the Teachable Moment Education Form for RN #1, dated 03/21/12, and RN #2, undated, revealed the two (2) nurses received education by the DNS.

*A review of the Ad Hoc PI Meeting Attendance and Agenda form, dated 04/06/12, revealed the agenda topics discussed included: Communication between departments and shifts, customer service, SBAR with reported change in condition and notification on changes in condition. The staff present were DNS, Social Services, Nutrition Services, Activities Director, Environmental Services and Licensed nurse. The document was signed by all staff present.

*A review of inservices, dated 04/06/12, revealed all staff were educated on Resident Change in Condition and Stop and Watch Form "Whenever a change of condition is identified in a resident, a Stop and Watch Form is to be filled ou and given to the Charge Nurse before the end of the shift." Documentation of Resident Change in Condition "Whenever a change of condition is identified in a resident, the SBAR Form must be filled out before the physician is notified. The completed form is to be placed in the progress notes. All changes in condition must be written on the 24 hour report book to pass on to the oncoming shift for follow up." Guidelines for Physician Notification of Change in Condition "When you have a resident with a change in condition, refer to the Guidelines for Physician Notification of Change of Condition Tool to determine the timeline of notification. The Guidelines are located on all Medication Administration Record

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(MAR) books and can be pulled from the computer TL6102-03." Customer Service "When a family or resident voice a concern, particularly on a change in condition, proper notification must be made. Even if we don't see the problem they have brought to us, it is a huge problem to the person voicing the concern. The staff is to act as advocates for our resident and families." Therapy, Dietary, Activities and Housekeeping were inserviced related to completing a Stop and Watch form. A list of employees was compared against the inservice sign in sheets. All employees were inserviced on 04/06/12.

*A review of a Teachable Moment - Education Form, dated 04/18/12, revealed LPN #2 received a teachable moment from LPN #1 related to evaluation of a resident's for change in condition via SBAR evaluation form, complete thorough evaluation. The discussion with the employee and reason for the teachable moment was related to, "failed to complete SBAR assessment tool with a condition change of Resident 150 B left eye read and draining. The document was signed by LPN #1 and LPN #2.

*A review of a Teachable Moment - Education Form, dated 04/23/12, revealed RN #7 received a teachable moment from the Assistant Director of Nursing Services (ADNS) related to completing an SBAR evaluation form. The discussion with the employee and reason for the teachable moment was related to, "any time you are given a Stop and Watch form, an SBAR must be filled out. The document was signed by RN #1 and ADNS.

*An interview with the DNS, on 05/08/12 at 9:35

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F 309	Continued From page 35 AM, revealed the facility had a PI meeting on 04/27/12 to follow up on a corrective action plan. The only issue identified was two (2) nurses, RN #7 and LPN #1, had missed completing the SBAR form. She stated a teachable moment with the two (2) nurses was completed. She stated the facility had implemented a change of condition audit tool and had identified all residents that needed to be sent out of the facility. She stated the facility continued to utilize the change of condition audit tool. *An interview with RN #7, LPN #2, LPN #3, SRNA #5, SRNA #6, SRNA #7, Housekeeping staff, and COTA #2, on 05/08/12 between 11:14 AM and 12:40 PM, revealed they were inserviced on the stop and watch form, who to report a change in condition to, completing the SBAR, assess the resident, notify the physician, supervisor, ADNS and document the assessment. No concerns were identified. *An interview with the Medical Director, on 05/03/12 at 12:30 PM, revealed the facility notified him of the change in condition for Resident #1 on 02/21/12 and the staff was directed to send the resident to the ER.	F 309		
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 36 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to maintain a clinical record related to accurately documenting an assessment due to a change in condition for one resident (#1), in the selected sample of three (3) residents. The facility failed to follow their "Condition Change of a Resident" policy and procedure. Resident #1 was admitted to the facility with a diagnosis to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis. On 02/17/12, Physical Therapist Assistant (PTA), State Registered Nurse Aide (SRNA) #1 and the Resident's daughter notified facility nurses about a noticeable change in condition for Resident #1. The resident's left side neglect was worse and he/she was unable to turn his/her head. On 02/18/12 and 02/19/12, SRNA #3 notified a facility nurse that there seemed to be a "360 degree change" in the resident. On 02/20/12, the Occupational Therapist (OT) notified nursing "of [resident's] worsening of status including, severe left neglect/decreased reaction, impaired posture control and suspicion of additional CVA with nursing currently addressing/verbalizing understanding." There was no documented evidence that facility nurses assessed Resident #1 for a change in condition, communicated the	F 514	Past noncompliance: no plan of correction required.	

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concerns reported to oncoming shift nurses or notified the physician of the multiple reports of a change in Resident #1. On 02/21/12, the resident's daughter spoke with the Director of Nursing Services (DNS). The resident was was sent out and admitted to the hospital. He/she presented with an acute onset of left-side facial droop and deviation of his/her eyes to the left side. The physician revealed Resident #1 clearly showed evidence of a stroke on 02/21/12. The facility failed to provide documented evidence of an assessment for signs and symptoms of a change in condition for Resident # 1 after multiple facility staff and family notified nursing of concerns related to the changes in Resident #1.

This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 02/17/12 through 04/28/12. The facility implemented corrective action which was completed prior to the State Agency's investigation, thus it was determined Past Jeopardy.

This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 02/17/12 through 04/28/12. The facility implemented corrective action which was completed prior to the State Agency's investigation, thus it was determined Past Jeopardy. (Refer to F309)

Findings include:

The facility's policy/procedure, "Condition Change of a Resident," dated 10/31/06, revealed it is the

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responsibility of the licensed nurse to "assess resident, take vital signs and include temperature, gather and organize the resident information (chart, medication list, vital signs, etc.) for physician notification, monitor and reassess resident's condition and response to interventions until stable." An interview with the Physical Therapist (PT), on 05/04/12 at 10:30 AM, revealed "It is PT policy, we notify nursing if we see a problem with a resident."

The facility admitted Resident #1 on 02/06/12 with diagnoses to include History of Cerebral Vascular Accident (CVA) with left-side hemiparesis on 12/20/11, History of Gastrointestinal Bleed and Chronic Renal Failure. A review of the admission Minimum Data Set (MDS) assessment, dated 02/13/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of nine (9). The resident was totally dependent on one staff for dressing, personal hygiene and bathing. He/she required extensive assistance of two staff for bed mobility, transfer and toilet use and limited assistance with eating.

A Weekly - Occupational Therapy (OT) Progress Note (PN), dated 02/13/12, revealed "[resident] demonstrates fair progression towards established goals including sitting tolerance 30-45 seconds. Left visual awareness with maximum verbal cues." A review of a Physical Therapy (PT) Progress Note (PN), dated 02/14/12, revealed "improvement noted in tolerance and mobility."

A PT Rehab Addendum Note, dated 02/17/12, revealed "[resident] noted to have more significant left-side neglect today and unable to

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respond to verbal and tactile cues made from [his/her] left side. Whereas, yesterday, [he/she] was able to follow verbal cues. Nursing notified of recent changes." The document was signed by the Physical Therapist Assistant (PTA). On 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, respectively, an interview with the PTA, revealed while she was providing physical therapy to Resident #1 on 02/17/12, she noticed the resident with more left-sided neglect, and was unable to respond to verbal tactile cues or to follow her past midline, which was different from the previous day. She stated she returned the resident to the unit and reported the change of condition to RN #1. She stated she asked the nurse to assess the resident. She further stated approximately one hour later she followed up with RN #1. RN #1 told her that she did not see a change of condition in Resident #1. The PTA stated she also notified her PT supervisor of the change of condition in Resident #1. An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed when Resident #1 was admitted to the facility he/she was able to move the right arm, turn his/her head and wiggle his/her toes. She stated that she and the PTA, on 02/16/12 or 02/17/12, noticed the resident was unable to turn his/her head. "It just stayed to the side. He/she stopped wiggling his/her toes and fingers and that was a difference." We notified RN #1 regarding the change of condition. She stated RN #1 told them that Resident #1 had a stroke, and this was why he/she was like that. She stated she told RN #1 the resident was not like that a few days ago. An interview with the PT, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, she was aware there was a change of condition in Resident #1, because the PTA notified her that there had been a

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change in condition for Resident #1. She stated that she and PTA discussed the changes related to his/her ability to follow cues and balance. She stated she advised the PTA to notify the nurse about the change of condition.

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed that PTA, on 02/17/12, had contacted RN #1 related to Resident #1's change in condition. RN #1 said she did not see any change in Resident #1 and asked me to go with her to assess the resident on 02/17/12. She stated, that on 02/17/12, she was not aware that the PTA had reported a change of condition in the resident. She stated "I just knew someone had reported a change in the resident. I thought everything was fine, because I did not see a change in the resident."

An interview with the Resident #1's daughter, on 05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, respectively, revealed she reported to RN #5, on the 3 PM to 11 PM shift, on 02/17/12 and 02/20/12, that she had noticed a marked difference in the resident. She stated she advised RN #5 the resident was not communicating as well and drawing up to the left side. She stated the nurse said she had not noticed any change at all in the resident.

There was no documented evidence that the nursing staff conducted an assessment to determine if there was a significant change in the resident's condition on 02/17/12.

On 05/06/12 at 9:05 and 9:22 AM, an interview with SRNA #3 revealed she worked on 02/18/12 and 02/19/12 on the 11-7 shift and had provided

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care for Resident #1. She stated the resident, prior to 02/18/12, had wanted to get up and help with toileting. She stated, on 02/18/12 and 02/19/12, the resident was less eager to help and did not seem happy. She stated "it was like a 360 degree change." She stated she notified RN #3 that "the resident seemed different and was not [himself/herself]." She stated RN #3 and an LPN assessed the resident on 02/18/12. She further stated when she returned to work, on 02/19/12, she felt perhaps the resident had not progressed and his/her condition was a little worse. She said she notified RN #3 again and the two of them went in the resident's room. She stated RN #3 asked her to stay in the room and watch the resident. She stated RN #3 stated "God, I hope she does not die." She stated she asked the nurse "was she going to send the resident out." She stated RN #3 said, "No, I cannot send [him/her] out." SRNA #3 stated "I do not know what she meant by that."

An interview with RN #3, on 05/03/12 at 4:00 PM, revealed she had no recollection of a change in condition in Resident #1. She stated she did not get a report from any staff or nurses about a change in the resident's condition.

There was no documented evidence that the nursing staff conducted an assessment to determine if there was a significant change in the resident's condition on 02/18/12 or 02/19/12.

The Weekly - Occupational Therapy (OT) PN, dated 02/20/12, revealed [resident] demonstrates "sitting tolerance 45 seconds to one (1) minute. [Resident] presents with severe left neglect during therapy, decreased positioning, decreased

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balance and decreased strength, left hemiplegia and left neglect."

The OT Rehab Addendum Note, dated 02/20/12, revealed "nursing notified of [resident's] worsening of status including, severe left neglect/decreased reaction, impaired posture control and suspicion of additional CVA with nursing currently addressing/verbalizing understanding."

On 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PMAn interview with the PTA revealed she and the Occupational Therapist (OT), on 02/20/12, were co-treating Resident #1 because he/she was a difficult resident. She stated she asked the OT to report a change of condition to the nurse since she had reported the change to the nurse on Friday, 02/17/12. She stated, "If more than one person notices a change, I like to make sure the nurse knows it is more than one discipline."

An interview with the OT, on 05/03/12 at 11:55 AM, revealed, prior to 02/17/12, she was able to cue Resident #1 to attend to his/her left visual field. She stated, that on 02/20/12, she noticed the resident's left-side neglect was much more severe. "I had to physically try to move the resident's head to the left." She said she notified RN #1 immediately of the change of condition on 02/20/12 and documented that nursing was notified. She stated RN #1 advised her that she would contact the daughter. She verbalized understanding of what I was reporting to her. Later, on 02/20/12, I followed up with RN #1. She again advised me she was going to contact the daughter. She further stated "I expected the nurse would contact the physician

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and report the change of condition."

An interview with RN #2, on 05/03/12 at 2:35 PM, revealed they assessed the resident's grip, swallowing ability and speech. She stated she did not notice a change in the resident's condition. She stated she asked RN #1 to "make a good nurse's note, but neither of us documented the assessment." A review of the nurse's notes, dated 02/17/12 through 02/20/12, revealed no evidence of a nursing assessment for Resident #1 or that the physician was noted of a change in condition.

An interview with SRNA #1, on 05/02/12 at 2:35 PM, revealed, that on the morning of 02/21/12, while she was assisting the resident with eating breakfast, the resident's daughter came in. She stated the daughter commented the resident was "pocketing food worse." She stated the daughter asked if I had noticed a change in the resident, and I told her yes, and I had reported it to my nurse. SRNA #1 asked RN #1 to speak to the daughter. She stated the daughter became upset with RN #1 about not being notified about Resident #1's change in condition. She stated RN #1 told the daughter she had talked to someone. The daughter stated "No one talked to me." An interview with the PTA, on 05/02/12 and 05/03/12 at 2:00 PM and 3:05 PM, revealed, on the morning of 02/21/12, as she began physical therapy with Resident #1, his/her daughter came to the therapy room and asked if she had noticed a change in Resident #1. She stated she told the daughter she had noticed a difference on 02/17/12. She stated the daughter asked if there was someone she could speak to. She stated

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she escorted the daughter to the DNS. PTA stated "Resident #1 was sent out of the facility." Further review of a PT PN, dated 02/21/12, revealed "Resident #1 experienced a decline in condition at the end of last week, nursing notified of change and decline in status, left-side neglect, decreased strength, decreased mobility and decreased sitting balance." An interview with the PT, on 05/04/12 at 10:30 AM, revealed, on 02/17/12, she was aware there was a change of condition in Resident #1, and further stated "I know that the change, we noted, was not transient." She stated she was aware that OT also noted a change of condition in Resident #1 and documented the same in her addendum note.

An interview with the Resident #1's daughter, on 05/03/12 and 05/07/12 at 8:25 AM and 11:20 AM, revealed she spoke with the PTA on 02/21/12, and asked her if she had noticed a change in the resident. She told me yes, and she had documented there was a change of condition in Resident #1. The daughter stated she asked the PTA why no one had notified her. She stated the PTA told her she did not know why I was not notified, but she had done what she was suppose to do by notifying the nurse. She stated the PTA took her to the DNS's office. She further stated she advised the DNS that she had noticed a change in the resident on 02/17/12, and that she had reported the change to RN #5. She stated she informed the DNS that the nurse had made her feel like she was overly concerned or exaggerating. She stated the DNS said the nurse had not made a report of the change of condition. The daughter stated "the nurse should have listened to my concerns, listened to the PTA and

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should have sent [the resident] to the hospital for evaluation."

The first notation related to a change of condition for Resident #1 in the medical record was on 02/21/12 at 9:00 AM. A Change of Condition Form revealed "Resident's family states that the resident is exhibiting signs and symptoms similar to those related to a previous CVA, such as pocketing food, inability to focus/concentrate and slight left-sided neglect. Requesting the resident be sent to the hospital for an evaluation. The physician was made aware with a new order received to send to the ER for an evaluation to rule out CVA."

A review of the Magnetic Resonance Imaging (MRI) report, completed on 02/21/12, revealed "Impression: Acute ischemic changes were seen around the peripheral area of chronic ischemic changes in the distribution of the right middle cerebral artery in the right temporal parietal lobe."

The OT Discharge Summary, dated 02/22/12, revealed "[resident] demonstrates noted regression secondary to increased left neglect with patient demonstrating right lateral cervical rotation to 80 degrees, unable to cross midline to left. [Resident] also with significant left lateral lean with suspected worsening of conation times one day observation of therapist." The PT Discharge Summary, dated 02/22/12, revealed "treatment initially successful; however, overall to date no progress related to the recent decline. Reason for Discharge: Change in medical status requiring hospitalization."

A review of a Teachable Moment - Education

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Form, dated 03/21/12, revealed the facility conducted a teachable moment with RN #1 by the DNS related to improved communication and customer satisfaction. The discussion with an employee and the reason for a teachable moment was related to, "if therapy staff communicates a concern with a resident, communicate with the family after assessing the resident. If your assessment does not indicate a problem but the family is still concerned, communicate their concern to the physician. Ask the family what they would like done, whether to treat in house or send for an evaluation to the Emergency Room (ER)." The document was signed by the DNS and RN #1.

A review of a Teachable Moment - Education Form, undated, revealed the facility conducted a teachable moment with RN #2 by the DNS related to accurate documentation of a resident's change in condition. The discussion with an employee and the reason for a teachable moment was related to, "On 02/17/12 you accompanied RN #1 to do an assessment on Resident #1 with a reported change in condition. As the Unit Manager, it is your responsibility to make sure the assessment was documented." The document was signed by the DNS and RN #2.

A review of the facility's Final Investigation Summary, dated 04/13/12, revealed, on 02/17/12, Physical Therapist Assistant (PTA) notified RN #1 that she noticed a change of condition in Resident #1. She advised RN #1 the resident's left side neglect was worse. RN #1 followed up with the PTA and advised the PTA that the resident was lying on his/her left side in the bed

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and the resident was able to track her all the way to the window. The PTA stated the resident's daughter approached her in the therapy department, on 02/21/12, and asked her if she had noticed any changes in the resident. PTA stated that she told the resident's daughter that she reported a change to nursing and took the resident's daughter to the DNS's office. RN #2 stated, that on 02/17/12, RN #1 came to her and advised her that therapy had voiced a concern about a change in condition regarding Resident #1. RN #2 accompanied RN #1 to assess Resident #1. They did not notice any changes in his/her condition. RN #2 completed Resident #1's skin assessment upon admission on 02/06/12. The area on the resident's left buttock was a Stage III and measured 2.8 centimeters (cm) by 2.0 cm. The area had necrotic tissue over 50% but less than 75% of the wound. Treatment was Santyl with foam and a dry dressing. SRNA #1 stated she noticed something different about Resident #1 and told RN #1 on 02/17/12. An interview with the DON, on 05/04/12 at 2:50 PM, revealed she did not realize there was a problem until Adult Protective Services (APS) came to the facility, on 04/06/12, and requested copies of the resident's chart concerning a pressure sore and the resident's stroke. She stated she was informed by APS about the concern, and she initiated an investigation at that time. Through their investigation process, the facility determined there were no neglect issues regarding Resident #1, and unsubstantiated the allegation.

An interview with the DNS, on 05/02/12 at 2:55 PM, revealed she first became aware of a concern with Resident #1 on the morning of

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02/21/12. She stated the PTA brought Resident #1's daughter to her office because she was "upset about the resident's condition." She stated the daughter told her she was noticing some of the same symptoms the resident had exhibited with his/her prior stroke, "pocketing food and looking to the left." She stated after the resident was sent out to the hospital, she went to RN #1 and RN #2 and asked them, what happened on 02/17/12. They stated the PTA had advised them of a change of condition in Resident #1. RN #1 and RN #2 told me they did an assessment, and they did not observe a change of condition with the resident. She further stated they did not document the assessment and had no reason for not documenting the assessment. She stated she addressed with RN #1 and RN #2 when a change of condition was reported, they were to complete a Situation Background Assessment Request (SBAR) form, and then they were to notify the physician. She further stated she did re-education with RN #1 and RN #2 related to completing the SBAR, physician notification and being an advocate for the resident and family. She stated, "It is not at the nurse's discretion not to report. They are required to report even if it is just the family reporting a change to them."

An interview with Resident #1's physician, on 05/03/12 at 10:00 AM, revealed that he admitted Resident #1 to the hospital on 02/21/12. He stated he/she presented with acute onset of left-side facial droop and deviation of his/her eyes to the left side. He stated Resident #1 "clearly showed evidence of a stroke on 02/21/12. He stated if a person shows signs of a stroke, we want them sent to the ER right away. He stated the MRI on 02/21/12 revealed the resident had a

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stroke.

**The facility implemented the following actions to correct the deficiency:

*The resident's physician/medical director was notified of resident's change of condition on 02/21/12 and he/she was sent to the ER.

* The facility had an Ad Hoc PI meeting held on 04/06/12 with IDT to review communication between departments and shifts, customer service, changes in resident condition and notification of changes in condition.

*An in-service was conducted for all staff on 04/06/12 to educate them on the Stop and Watch form, the 24 hour report book, being an advocate for our customers, the Situation Background Assessment Request (SBAR) form with a change of condition and guidelines for physician notification on change of condition.

*An audit tool was implemented to identify residents with a change in condition. The audit tool is ongoing on residents with a change in condition.

**The surveyor validated the corrective action taken by the facility as follows:

An interview with the Medical Director, on 05/03/12 at 12:30 PM, revealed the facility notified him of the change of condition for Resident #1 on 02/21/12 and the staff was directed to send the resident to the ER.

A review of the Teachable Moment Education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING _____ B. WING _____	C 05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	550 HIGH ST. BOWLING GREEN, KY 42101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 50	F 514		

Form for RN #1, dated 03/21/12 and RN #2, undated, revealed the two (2) nurses received education by the DNS.

A review of inservices, dated 04/06/12, revealed all staff were educated on Resident Change in Condition and Stop and Watch Form "Whenever a change of condition is identified in a resident, a Stop and Watch Form is to be filled ou and given to the Charge Nurse before the end of the shift." Documentation of Resident Change in Condition "Whenever a change of condition is identified in a resident, the SBAR Form must be filled out before the physician is notified. The completed form is to be placed in the progress notes. All changes in condition must be written on the 24 hour report book to pass on to the oncoming shift for follow up." Guidelines for Physician Notification of Change in Condition "When you have a resident with a change in condition, refer to the Guidelines for Physician Notification of Change of Condition Tool to determine the timeline of notification. The Guidelines are located on all Medication Administration Record (MAR) books and can be pulled from the computer TL6102-03." Customer Service "When a family or resident voice a concern, particularly on a change in condition, proper notification must be made. Even if we don't see the problem they have brought to us, it is a huge problem to the person voicing the concern. The staff is to act as advocates for our resident and families." Therapy, Dietary, Activities and Housekeeping were inserviced related to completing a Stop and Watch form. A list of employees was compared against the inservice sign in sheets. All employees were inserviced on 04/06/12.

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F 514	Continued From page 51	F 514		

A review of the Ad Hoc PI Meeting Attendance and Agenda form, dated 04/06/12, revealed the agenda topics discussed included: Communication between departments and shifts, customer service, SBAR with reported change in condition and notification on changes in condition. The staff present were DNS, Social Services, Nutrition Services, Activities Director, Environmental Services and Licensed nurse. The document was signed by all staff present.

A review of Teachable Moment - Education Form, dated 04/18/12, revealed LPN #2 received a teachable moment from LPN #1 related to evaluation of a resident's for change in condition via SBAR evaluation form, complete thorough evaluation. The discussion with employee and reason for teachable moment was related to, "failed to complete SBAR assessment tool with condition change of Resident 150B left eye read and draining. The document was signed by LPN #1 and LPN #2.

A review of Teachable Moment - Education Form, dated 04/23/12, revealed RN #7 received a teachable moment from Assistant Director of Nursing Services (ADNS) related to completing SBAR evaluation form. The discussion with employee and reason for teachable moment was related to, "any time you are given a Stop and Watch form, an SBAR must be filled out. The document was signed by RN #1 and ADNS.

An interview with RN #7, LPN #2, LPN #3, SRNA #5, SRNA #6, SRNA #7, Housekeeping staff, and COTA #2, on 05/08/12 between 11:14 AM and 12:40 PM, revealed they were inserviced on the stop and watch form, who to report change in

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F 514	Continued From page 52 condition to, completing the SBAR, assess the resident, notify the physician, supervisor, ADNS and document assessment. No concerns were identified. An interview with the DNS, on 05/08/12 at 9:35 AM, revealed the facility had a PI meeting on 04/27/12 to follow up on corrective action plan. The only issue identified was two (2) nurses, RN #7 and LPN #1, had missed completing the SBAR form. She stated a teachable moment with the two (2) nurses was completed. She stated the facility had implemented a change of condition audit tool and had identified all residents that needed to be sent out of the facility. She stated the facility is continuing to utilize the change of condition audit tool.	F 514		